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SHEET METAL WORKERS' HEALTH PLAN OF SOUTHERN CALIFORNIA, ARIZONA AND NEVADA

RETIREE HEALTH PLAN

SUMMARY PLAN DESCRIPTION AND PLAN DOCUMENT

MEDICAL AND PRESCRIPTION DRUG BENEFITS FOR RETIRED PARTICIPANTS AND ELIGIBLE DEPENDENTS

REVISED JULY 1, 2017

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QUICK REFERENCE CHART

Mailing addresses are listed on page 44 of this booklet.

HEALTH PLAN ADMINISTRATIVE OFFICE	
• **Questions about retiree eligibility or general information** • **Questions about eligibility for dependents** • **Questions about return to work policies** • **Questions about retiree self-pay rates** • **HIPAA Privacy Notice, Privacy & Security Officers**	**800-947-4338** **or visit the Plan's website: www.sheetmetalsam.org**

HMO/EPO OPTIONS – Questions about providers, benefits or claims		
	Non-Medicare Plan	**Medicare Plan**
• **Kaiser HMO - California**	**800-464-4000 or www.kp.org**	**800-777-1238 or www.kp.org**
• **UnitedHealthcare HMO - California**	**800-624-8822 or www.myuhc.com**	**800-457-8506 or www.UHCRetiree.com**
• **Health Net HMO - California**	**800-522-0088 or www.healthnet.com**	**800-275-4737 or www.healthnet.com/medicare**
• **Health Plan of Nevada (HPN) HMO - Nevada**	**800-777-1840 or www.healthplanofnevada.com**	**800-650-6232 or www.SeniorDimensions.com**
• **UnitedHealthcare EPO - Nevada**	**800-377-5154 or www.myuhc.com**	**800-457-8506 or www.UHCRetiree.com**
• **Hometown Health HMO - Nevada**	**800-336-0123 or www.hometownhealth.com**	**No Medicare option offered**
• **UnitedHealthcare HMO - Arizona**	**800-377-5154 or www.myuhc.com**	**800-457-8506 or www.UHCRetiree.com**

Please visit the Plan's website at www.sheetmetalsam.org where you can obtain Plan information, forms, and other materials at no cost.

Keep the Plan Informed of Address Changes

To ensure that you receive the benefits that you are entitled to, as well as any important communications, you MUST keep the Administrative Office informed of any address changes for yourself and any eligible dependents. You must also notify the Administrative Office immediately of any change in status of family members, including births, deaths, or divorces.

To protect you and your family's rights, all such changes must be received in writing. You should also keep a copy, for your records, of any notices you send to the Administrative Office.

Foreign Language Assistance / Asistencia Lengua Extranjera

This booklet contains a summary in English of your plan rights and benefits under the Plan. If you have difficulty understanding any part of this booklet, contact the Administrative Office either in person or by telephone.

AVISO A LOS PARTICIPANTES QUE HABLAN ESPAÑOL: Si tiene alguna pregunta tocante este folleto, o requiere alguna otra información tocante a su cobertura de salud, por favor no dude en comunicarse con la Oficina Administrativa al (800) 947-4338, donde habrá varios representantes bilingües que con gusto le ayudarán.

SHEET METAL WORKERS' HEALTH PLAN OF SOUTHERN CALIFORNIA, ARIZONA AND NEVADA

111 North Sepulveda Boulevard, Suite 100
Manhattan Beach, California 90266-6861
Telephone: (800) 947-4338
Website: www.sheetmetalsam.org

Dear Retiree Health Plan Participant:

This booklet is specifically for retired participants and their eligible dependents who live within a geographical area serviced by one or more of the HMOs/EPOs offered through the Retiree Health Plan. Except for a limited group of grandfathered participants who retired prior to January 1, 2003, and as of December 31, 2002, did not reside in any of the HMO service areas, the Plan does **not** offer any retiree coverage for retired participants and their dependents who do not live within one of the Retiree Health Plan's HMOs/EPOs service areas. To confirm that you live within an HMO/EPO service area, you should contact the Administrative Office at the telephone number above.

The Retiree Health Plan's coverage options for retired participants who live in an HMO/EPO service area consist of a number of HMO/EPO options, some designed specifically for those enrolled in Medicare and others designed for those not yet eligible to enroll in Medicare. The number and type of HMO/EPO options from which you can choose will vary depending on where you live. Summaries of all the options are contained in the inside front pocket of this booklet. Please remember though, that not all of the HMO/EPO options will be available to you – those available to you will depend on where you live.

Once you have enrolled in one of the Retiree Health Plan's HMO/EPO options you should refer to the Evidence of Coverage/Disclosure booklet issued by the HMO/EPO to determine your benefits and how to use the program. We urge you to keep that booklet in the front or back pocket of this booklet for ease of reference. You should refer to this booklet, which is issued directly by the Plan, for the eligibility rules and general provisions which apply to all health coverages offered to retired sheet metal workers and their eligible dependents.

If you have any questions about eligibility or benefits, please refer to the Quick Reference Chart at the beginning of this booklet for the contact information you should use to get the answers you are seeking.

Sincerely,

THE BOARD OF TRUSTEES

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Please refer to your HMO or EPO evidence of coverage booklet for your health benefits, how to obtain services and supplies, and claims and appeals procedures. You should keep these booklets and brochure in the inside front or back cover of this booklet for easy reference.

IMPORTANT NOTE: The Retiree Health Plan described in this document is effective January 1, 2017, except for those provisions that specifically indicate other effective dates, and replaces all other summary plan descriptions or benefit booklets and inserts to those documents previously provided to you.

RETIREE HEALTH PLAN OVERVIEW

Below is an overview of:

- **Eligibility for the Retiree Health Plan**
- **Benefit Options under the Retiree Health Plan**

For a more complete description of eligibility requirements, please refer to the following Chapters of this booklet (these are named in the preceding Table of Contents). Please refer to the benefit booklet issued by the HMO or EPO for details on benefits, how to obtain care and claims filing and review procedures.

NOTE: Capitalized terms used in this SPD have a precise meaning (for example, "Retired Participant," or "Sheet Metal Industry"). To be sure you understand the meaning of capitalized terms, please refer to the Glossary which starts immediately after Chapter 3 of this booklet.

The eligibility rules that apply to all options and coverages under the Retiree Health Plan are contained in Chapter 1 of this booklet.

Overview of Eligibility	
Type of Individual	**Eligibility Requirement**
Retired Participants ***Refer to Chapter 1 for details, including special provisions regarding working in Non-Covered Sheet Metal Service, and pro-rata pensions.***	Retired participants who are receiving a Pension Benefit and reside within an applicable HMO or EPO service area may be eligible to elect and pay for coverage under this Retiree Health Plan. Some exceptions apply – refer to Chapter 1.
Initial Enrollment ***Refer to Chapter 1 for details, including application and self-payment deadlines.***	Retired participants are given the opportunity to enroll at the time they apply for Pension Benefits. If you do not enroll yourself and your eligible dependents when you apply for your Pension Benefits, you will have a one-time opportunity to enroll at a later date, **BUT YOU MAY HAVE TO PAY MORE FOR YOUR COVERAGE.**
Dependents – legal spouse and, in some limited circumstances, children to age 19 (to age 23 if full-time students) ***Refer to Chapter 1 for details, including special rules for dependent children, and coverage extensions in the event of a retired participant's death.***	Must be listed on the enrollment forms and proof of dependency documentation must be submitted when due (including upon subsequent request); dependents are generally eligible during the period that the participant to whom they are related is eligible. **Your newly acquired dependent should be properly enrolled within 31 days following the date you acquired the dependent.**

Overview of Eligibility	
Surviving Dependents of a Deceased Active Participant (children must meet Retiree Health Plan criteria to be eligible) ***Refer to Chapter 1 for details.***	Surviving Dependents may enroll in this Retiree Health Plan if, as of the date of the Active Participant's death, the Active Participant was covered under a health care option offered by the Active Plan and the Active Participant's surviving spouse or beneficiaries were entitled to a pre-retirement survivor annuity or pre-retirement death benefits from the Pension Plan.
Surviving Spouses of a Deceased Retired Participant ***Refer to Chapter 1 for details.***	Surviving spouses may enroll in this Retiree Health Plan if, as of the date of the Retired Participant's death, the surviving spouse was enrolled as an eligible dependent on the Retiree Health Plan.

Overview of Medical Options

Please note that from time to time the options offered under the Retiree Health Plan may change and/or the service areas covered by the options may change. You should contact the Administrative Office or visit the Plan's website at sheetmetalsam.org for an up-to-date listing of options and service areas.

Benefit	Description
Medical Options for retired participants not eligible for Medicare ***These options are only available if you are not eligible to enroll in Medicare.***	**You may choose one of these applicable Options:** ***In Arizona –*** • UnitedHealthcare EPO ***In California –*** • Kaiser HMO • UnitedHealthcare HMO • Health Net HMO ***In Nevada –*** • UnitedHealthcare EPO • Health Plan of Nevada (HPN) HMO • Hometown Health HMO (Northern Nevada only)

Overview of Medical Options *Please note that from time to time the options offered under the Retiree Health Plan may change and/or the service areas covered by the options may change. You should contact the Administrative Office or visit the Plan's website at sheetmetalsam.org for an up-to-date listing of options and service areas.*	
Medical Options for retired participants enrolled in Medicare ***These options are only available if you are enrolled in both Part A and Part B of Medicare and you assign your Medicare benefits to the HMO.***	***In Arizona –*** • UnitedHealthcare Medicare Advantage HMO ***In California –*** • Kaiser Senior Advantage HMO • UnitedHealthcare Medicare Advantage HMO • Health Net's Seniority Plus HMO ***In Nevada –*** • UnitedHealthcare Medicare Advantage HMO • Health Plan of Nevada's (HPN) Senior Dimension HMO

CHAPTER 1 - ELIGIBILITY RULES FOR COVERAGE

The eligibility rules outlined in this booklet apply to all the benefit options provided by or through the Retiree Health Plan to retired participants.

In this Chapter you'll find information on:

- **Who is eligible**
- **When and how to enroll in coverage**
- **Open enrollment**
- **Self-pay requirements**
- **Coverage effective dates and termination dates**
- **Rules concerning work after retirement**
- **Qualified medical child support orders**
- **COBRA continuation coverage**

WHO IS ELIGIBLE

Eligible Retired Participants

Retired participants are eligible to elect and pay for Retiree Health Plan coverage if they meet all of the following requirements:

- reside within an applicable HMO or EPO service area,
- if eligible for Medicare, they must enroll in Parts A and B of Medicare and assign their Medicare benefits to the applicable HMO,
- qualify for a Pension Benefit from the Sheet Metal Workers' Pension Plan of Southern California, Arizona and Nevada (the "Pension Plan"),
- for retirements occurring on or after July 1, 2016, have at least 15 years of pension credit (as defined in the Pension Plan) earned in the Pension Plan (reciprocal pension credits do not apply); some exceptions apply – see "Exceptions" below, and
- at least two of the pension credits must have been earned in the 60 months (5 years) prior to the effective date of the Pension Benefits, during which time contributions were made to the Plan; some exceptions apply – see "Exceptions" below.

Exceptions:
Exception #1 - A retired participant who is awarded a Disability Pension from the Pension Plan, and who became Disabled during a time period in which he was actively engaged in sheet metal employment for a Contributing Employer to the Plan, or was running out his or her hour bank, shall be treated as having met the following eligibility requirements for Retiree Health Plan coverage: (1) 15 years of pension credit, and (2) two pension credits in the last five years prior to retirement.

Exception #2 - An otherwise eligible retired participant who does not have two pension credits in the Pension Plan in the five years prior to retirement, or on whose behalf Plan contributions were not made during such period, may elect Retiree Health Plan coverage at the time of retirement provided he or she meets the following criteria: (1) the retiree must have been an owner or working in management for a Contributing Employer to the Plan, or working under a sheet metal workers or building trades collective bargaining agreement approved by the Trustees of the Plan, within six months of his or her pension effective date; (2) the retiree must have been an eligible active participant in the Plan for at least five years; and (3) comprehensive, reasonably available employment-based retiree health care coverage must not be otherwise available to the participant. Participants within this special coverage group must pay 100% of the actual cost to the Plan of their Retiree Health Plan coverage, and must elect such coverage within 30 days of their effective date (Annuity Starting Date) for Pension Benefits.

Retired participants that fall in one or more of the following categories are **NOT** eligible to participate in the Retiree Health Plan:

- A person who worked in two calendar quarters in the geographical jurisdiction of the Plan or a related plan, in Non-Covered Sheet Metal Service after February 1, 1986, either before or after retirement, is not eligible for Retiree Health Plan coverage unless that person returns to employment for a Contributing Employer for at least as long a period of time as that person worked in Non-Covered Sheet Metal Service. However, if such person again works in Non-Covered Sheet Metal Service in any two calendar quarters, he will not again be eligible for Retiree Health Plan coverage.

- A person receiving a Pro Rata Pension from the Pension Plan and whose last pension credits were not under the Pension Plan, is not eligible for Retiree Health Plan coverage.

  (A Pro Rata Pension is provided for Pension Plan participants who would not otherwise qualify for a pension, or whose pensions would be less than the full amount, because their years of employment were divided between the jurisdiction of the Pension Plan and a "related" pension plan. Pension credits are years of service earned by Participants and used to determine eligibility for pension benefits. These terms are more fully defined in the Pension Plan.)

- A person whose Pension Benefit is suspended by the Pension Plan is not eligible for Retiree Health Plan coverage during the period of suspension.

- A person receiving a Pension Benefit but who is working in suspendable sheet metal industry employment under the terms of the Pension Plan is not eligible for Retiree Health Plan coverage during the period of such work.

A retired participant who works in suspendable employment after retirement, including covered employment, may thereafter be considered a new retiree under Pension Plan rules. In that case, he or she must meet the requirement of having at least 15 pension credits in order to qualify for enrollment in the Retiree Health Plan, and his or her self-pay contribution rate will be based on

the rates applicable to the status of a new retiree.

Eligible Dependents

Retired participants or surviving spouses who enroll in the Retiree Health Plan may also enroll their dependents if such dependents meet the rules below and all the required documentation of dependent status is filed with the Administrative Office in a timely manner.

Eligible dependents include the participant's:

- legal spouse (former spouses are not eligible after the effective date of the final divorce decree);

- unmarried children but only under the following three instances:

  - if the participant met the requirements of, and is receiving, a Disability Pension (as defined in the Pension Plan) as of the date of his retirement,

  - if the child(ren) are surviving eligible dependents of a deceased active participant and the deceased active participant's surviving spouse is entitled to, and enrolls, in the Retiree Health Plan, provided the child(ren) were covered under the Active Plan immediately prior to enrollment in the Retiree Health Plan, or

  - if the child was totally prevented from earning a living because of a mental or physical disability, and
    i) was so disabled and covered under the Retiree Health Plan on June 30, 1988, or
    ii) after June 30, 1988 he was so disabled and covered under the active health Plan A immediately prior to the transfer of coverage to the Retiree Health Plan.

    Proof of continued disability must be submitted to the Administrative Office annually.

If one of the above three instances apply, the following additional requirements must be met in order for unmarried children to be eligible for enrollment:

Age Requirement -

- the children must be under 19 years of age, or

- the children must be between the ages of 19 and 23 and enrolled as a full time student (at least 12 units per semester or quarter) in an accredited institution of learning, (note that coverage is provided during the summer break if the child is under 23 years of age and was in school immediately prior to the summer break and is enrolled for the following semester or quarter), or

- at any age if the unmarried child is disabled as described above.

Dependency Status -

- disabled children age 19 or over must be **solely** dependent upon the retired participant or the retired participant's surviving spouse for support; students between the ages of 19 and 23 years must be primarily dependent upon the retired participant or the retired participant's surviving spouse for support, and

- the children must be the retired participant's natural children, legally-adopted children, children placed for adoption if under 18 years old, step children, or any other children for whom, by a Qualified Medical Child Support Order, the retired participant is legally responsible for the child's health care expenses. A child is "placed for adoption" on the date the participant first becomes legally obligated to provide full or partial support of the child whom the participant plans to adopt.

In no event will a spouse or child be covered simultaneously as a dependent and as a retired participant under the Retiree Health Plan or any coverage provided by the Plan, nor shall a spouse or child be covered simultaneously as a dependent of more than one retired participant under the Retiree Health Plan or any other coverage provided by the Plan.

In order to establish eligibility for your dependents, certain documents must be provided to the Administrative Office at the time you enroll the dependents. Contact the Administrative Office for details on the documentation that is required to be submitted.

You must IMMEDIATELY notify the Administrative Office in writing when changes in dependency status occur. This includes final dissolution of marriage, annulment, death, a former student over 19 not taking enough units at school, marriage of a child, or any other event that would make a dependent not eligible for further coverage.

Any premiums paid on behalf of retired participants and/or their dependents during any period of ineligibility must be repaid to the Plan by the participant and/or the dependent including attorney's fees, interest and reasonable collection costs. The Plan may recover these amounts through legal action or otherwise as determined in the sole and absolute discretion of the Board of Trustees or a duly authorized committee of the Board of Trustees. The retired participant and/or dependent may also be required to reimburse the Plan and/or the HMO/EPO for the value of any HMO/EPO benefits provided to the ineligible retired participant and/or ineligible dependent.

Special Provision for Surviving Spouses

There are two types of coverage extensions for surviving spouses as described below.

When death occurs prior to enrollment in the Retiree Health Plan

Surviving spouses of deceased sheet metal workers may enroll themselves and in some cases their eligible dependent children (refer to page 6) in the Retiree Health Plan if the following conditions are met:

- as of the date of the sheet metal worker's death, his surviving spouse was entitled to a pre-

retirement survivor annuity or pre-retirement death benefits from the Pension Plan (as defined in the Pension Plan), and

- as of the date of the sheet metal worker's death, he was covered under a health plan provided by the Plan, and

- the surviving spouse has not remarried.

Please note that the Plan's provisions regarding work in Non-Covered Sheet Metal Service as explained on page 5 also apply to this special surviving spouse provision. The work histories of both the surviving spouse and the deceased sheet metal worker will be reviewed individually when determining if the surviving spouse (and dependent children) are eligible to enroll.

When death occurs while enrolled in the Retiree Health Plan

If a retired sheet metal worker dies while he is a retired participant and covered under the Retiree Health Plan, his surviving spouse (and eligible dependent children) who are covered under the Retiree Health Plan as of the date of death, may continue coverage by making the required self-payments as discussed later in this Chapter.

WHEN AND HOW TO ENROLL IN COVERAGE

Retired participants are given the opportunity to enroll at the time they apply for Pension Benefits. The Administrative Office will provide you with the necessary paperwork and a description of your health care options. If you do not enroll yourself and your eligible dependents (or cannot enroll because you do not live within a contracted HMO or EPO service area) when you apply for your Pension Benefits, you will have a one-time opportunity to enroll at a later date, **BUT YOU MAY HAVE TO PAY MORE FOR YOUR COVERAGE – REFER TO THE SPECIAL ENROLLMENT PROVISION BELOW.**

Surviving Spouses who meet the criteria for coverage as described under Special Provision for Surviving Spouses must enroll by the date Pension Benefits become payable to the surviving spouse or by the first day of the month following the date of the retiree's death, whichever is later. If no Pension Benefits are payable to the surviving spouse, enrollment must occur by the first day of the month following the date of the retiree's death.

Adding New Dependents

Newly acquired eligible dependents (refer to page 6 for a description of eligible dependents) must be enrolled within 31 days from the date dependency status is met. If they are not enrolled by that date, you will not be permitted to enroll them at a later date unless they meet the requirements described under the Special Enrollment provision below.

In order to add new dependents to your coverage, certain documents must be provided to the Administrative Office along with the appropriate enrollment form. Contact the Administrative Office for the necessary form and details on what documentation must be submitted.

Special Enrollment

If a retired participant or surviving spouse does not enroll himself and/or his dependents when first entitled to do so, or, is unable to enroll because he resides outside any of the Plan's contracted HMO/EPO service areas, such retired participant or surviving spouse may enroll at a later date based on the following rules. **AS NOTED BELOW, YOUR SELF-PAY CONTRIBUTION MAY BE SIGNIFICANTLY HIGHER UNDER CERTAIN CIRCUMSTANCES IF YOU DO NOT ENROLL WHEN FIRST ENTITLED TO DO SO.**

➢ ***If you had other group coverage***

If you or your dependent, as appropriate, were covered under another group health plan or had health insurance coverage at the time you previously declined coverage under the Retiree Health Plan, you may still be eligible to enroll if all of the following conditions are met:

- at the time you or your dependent, as appropriate, declined coverage under the Retiree Health Plan, you provided written confirmation to the Administrative Office that coverage under another group health plan or health insurance program was the reason you declined coverage under the Retiree Health Plan (if the Administrative Office requested such confirmation); and
- you or your dependent's, as appropriate, prior coverage was terminated due to the loss of eligibility for coverage or the employer ceased making contributions for said coverage; and
- you submit a completed enrollment form for coverage under the Retiree Health Plan and any other requested documentation within 30 days after the date coverage is lost under the other plan. However, if you or your dependents lose eligibility for Medicaid or Children's Health Insurance Program (CHIP) coverage or become eligible for a state subsidy for enrollment in the Retiree Health Plan under Medicaid or CHIP, you must properly enroll your dependents in Retiree Health Plan coverage within 60 days after coverage in Medicaid/CHIP ends or the date /they became eligible for the subsidy; and
- you reside in a contracted HMO or EPO service area.

If these conditions are met and you meet the eligibility rules for the Retiree Health Plan, your coverage will begin as of the date the other coverage terminates. If you enroll under these circumstances your self-pay contribution will be the same as if you had enrolled when first eligible to do so.

➢ ***If you did not live in a contracted HMO or EOP service area***

If your initial enrollment for coverage under the Retiree Health Plan was disallowed because you did not live within a contracted HMO or EPO service area and you later move to an area in which contracted HMO or EPO coverage is available or a contracted HMO or EPO expands its service area to include where you live, you may enroll in whichever HMO or EPO is available to you provided you submit the necessary enrollment form and any other requested documentation to the Administrative Office within 31 days from the date you relocate or the date HMO or EPO coverage is otherwise available to you. (Note that EPO coverage is only available to non-Medicare eligible individuals residing in certain

geographical areas.)

Your coverage will begin the first day of the month following the date the Administrative Office receives your completed enrollment form and other requested documentation. If you enroll under these circumstances your self-pay contribution will be the same as what you would pay had you initially lived in an HMO or EPO service area.

- ***For any other reason***

If you do not fall into either of the above categories, you nevertheless have a one-time opportunity to enroll in the Retiree Health Plan after your initial enrollment date if you meet the eligibility rules for coverage under the Retiree Health Plan as described earlier in this Chapter, and you reside in a contracted HMO or EPO service area at the time application is made for coverage under this provision. It is up to you to decide when you want to enroll under this "one-time opportunity" provision. You must complete and submit an enrollment form to the Administrative Office along with any requested documentation. Your coverage will begin on the first day of the month following the date the Administrative Office receives your enrollment form and any requested documentation. **IF YOU ENROLL UNDER THESE CIRCUMSTANCES YOUR SELF-PAY CONTRIBUTION MAY BE SIGNIFICANTLY HIGHER THAN WHAT YOU WOULD PAY HAD YOU ENROLLED WHEN YOU WERE FIRST ELIGIBLE TO DO SO.**

If you want to enroll under these special enrollment provisions, contact the Administrative Office for enrollment materials and a description of the health care options available to you.

ANNUAL OPEN ENROLLMENT

Retired participants elect their health plan option at the time they first become eligible and may change their election only during an annual open enrollment period designated by the Plan unless they move their primary residence outside their selected option's service area or their selected option no longer offers coverage in their area. If you plan on moving outside your HMO's or EPO's service area notify the Administrative Office immediately. You may be able to enroll in another HMO or EPO offered by the Retiree Health Plan. Please note however, that if no contracted HMOs or EPOs are available to you in your area, you will not have any coverage from the Retiree Health Plan.

Shortly before each annual open enrollment period, the Administrative Office will send you information on the health plan options that may be available to you (depending on your Zip Code). You then have a specific period of time to decide if you want to change options and complete and mail your change to the Administrative Office. If you do not submit a new election by the end of the designated open enrollment period, you will retain the same health care option you had immediately prior to the annual open enrollment period.

If a retired participant also wants coverage for his or her eligible dependents, the eligible dependents must be enrolled in the same HMO or EPO option as the retired participant. However, the HMO benefit levels will differ for the retired participant and the eligible dependent if one is enrolled in Medicare Part A and B and the other is not eligible for Medicare. Refer to

the comparison of health care options in the front pocket of this booklet for a summary description of the Medicare and non-Medicare benefits.

SELF-PAY CONTRIBUTION REQUIREMENT

Retired participants and surviving spouses must contribute towards the cost of their health care coverage under the Retiree Health Plan. The monthly self-pay contribution rates are determined and periodically changed (usually annually) by the Board of Trustees in its sole and absolute discretion. If you want to know the amounts of the current monthly self-pay contribution rates, contact the Administrative Office.

With your authorization, the self-pay contribution will be deducted from your monthly Pension Benefit. However, if the self-pay contribution is more than your monthly Pension Benefit, no deduction will be made. Instead, you must submit the entire self-pay contribution by check or money order each month to the Administrative Office.

Self-pay contributions are due by the 20th day of the month preceding each coverage month. If a self-pay contribution is not received by the Administrative Office by the due date (or if your check is returned because of insufficient funds), your coverage, including any dependent coverage, will automatically terminate with no notice from the Plan. **ONCE TERMINATED UNDER THESE CIRCUMSTANCES, COVERAGE CANNOT BE REINSTATED NOR CAN YOU RE-ENROLL IN THE RETIREE HEALTH PLAN. THE ADMINISTRATIVE OFFICE WILL NOT SEND MONTHLY BILLS OR WARNING NOTICES. IT IS THE RESPONSIBILITY OF THOSE WHO ARE REQUIRED TO SUBMIT SELF-PAY CONTRIBUTIONS TO SUBMIT THEM WHEN DUE.** You may pay several months' self-payments in advance, if you want.

COVERAGE EFFECTIVE DATE

A retired participant who enrolls under the Retiree Health Plan at the time of his application for Pension Benefits will become covered under his selected health care option on the later of the following dates, provided all enrollment and self-pay contribution requirements are met:

- the date his Pension Benefits commence,
- the date his eligibility under the Plan's active Plan A or Plan B terminates, or
- the date his eligibility under the Arizona Sheet Metal Workers' Health Plan terminates.

A surviving spouse who enrolls under the Retiree Health Plan when first entitled to do so as outlined under Special Provision for Surviving Spouses, will become covered under his or her selected health care option on the later of the following dates that are applicable, provided all enrollment and self-pay contribution requirements are met:

- the first day of the month following the date of her spouse's death,
- the date Pension Benefits become payable to her,

- the date her eligibility under the Plan's active Plan A or Plan B terminates, or

- the date her eligibility under the Arizona Sheet Metal Workers' Health Plan terminates.

If you are enrolling under any of the conditions specified under Special Enrollment, refer to that provision for the date your coverage becomes effective.

If dependent coverage is elected and the dependent is listed on the enrollment form, such dependent will become covered under the HMO or EPO selected by the retired participant or surviving spouse on the date coverage is effective for the retired participant or surviving spouse, provided all requested documentation is submitted on a timely basis and the required self-pay contribution is made for the dependent. Note that benefit levels differ under the HMO options depending on whether or not an individual is enrolled in Medicare.

For newly acquired dependents and dependents enrolled under the Special Enrollment provision, coverage will begin on:

- the first day of the month following the date dependency status is met if an enrollment form adding the dependent is submitted to the Administrative Office within 31 days following the date dependency status is met (if you are eligible to enroll dependent children, a newborn child is covered from birth provided you submit an enrollment form for the child within 31 days following birth), or

- for those enrolling under the Special Enrollment provision, on the applicable date set forth in that provision.

COVERAGE TERMINATION DATE

Coverage for a retired participant or surviving spouse enrolled in the Retiree Health Plan will terminate as of whichever of the following dates occur first:

- the first day of the month in which eligibility for Pension Benefits terminates or is suspended, or is suspendable for any reason (including for work in Non-Covered Sheet Metal Service or in the Sheet Metal Industry),

- the first day of the month following 60 days from the date the Administrative Office receives a written request from the retired participant or surviving spouse to terminate coverage. If the retired participant or surviving spouse does not have the required self-pay contribution deducted from the monthly Pension Benefit (instead, payment is submitted to the Administrative Office by check or money order), coverage is automatically terminated as of the first day of a month if the required self-pay contribution is not received by the Administrative Office by the 20th day of the preceding month,

- the date coverage for the retired participant or surviving spouse is terminated by an HMO or EPO for cause (as defined in the service agreement between the Plan and the HMO or EPO) unless another HMO or EPO is available to the retired participant or surviving spouse and such individual enrolls in the other HMO or EPO within 31 days following the date coverage would otherwise terminate,

- the first day of the month following the date the retired participant or surviving spouse no longer resides in his/her selected HMO or EPO service area unless another HMO or EPO is available to the retired participant or surviving spouse and such individual enrolls in the other HMO or EPO within 31 days following the date coverage would otherwise terminate,

- for those enrolled in Medicare and covered under a Medicare advantage option offered by the Retiree Health Plan, the date such individual is no longer enrolled in Medicare Part A and Part B,

- for those enrolled in Medicare and covered under a Medicare advantage option offered by the Retiree Health Plan, the date the retired participant's or surviving spouse's Medicare assignment of benefits to the HMO under which he/she is enrolled, is no longer valid,

- the date the retired participant or surviving spouse would be initially covered by Medicare Part A and Part B if such individual enrolled when first eligible but fails to enroll,

- the date the Retiree Health Plan is terminated by the Board of Trustees,

- the date the eligibility rules are modified by the Board of Trustees to exclude a class of retired participants or surviving spouses in which the retired participant or surviving spouse belong,

- the date of entrance into full-time military service with the Armed Forces of the United States, or

- with respect to a surviving spouse, the first day of the month following the date the surviving spouse remarries.

A dependent's coverage will terminate as of whichever of the following dates occur first:

- the date the retired participant's or surviving spouse's coverage terminates for reasons other than the death of the retired participant. In the event of the death of the retired participant, dependents may continue coverage in accordance with the Special Provision for Surviving Spouses (page 7),

- the first day of the month following the date the dependent no longer meets the Retiree Health Plan eligibility requirements for dependents,

- the date coverage for the dependent is terminated by an HMO or EPO for cause (as defined in the service agreement between the Plan and the HMO or EPO) unless another HMO or EPO is available to the retired participant or surviving spouse upon whose eligibility the dependent's coverage is based and such retired participant or surviving spouse enrolls in another HMO or EPO within 31 days following the date coverage would otherwise terminate,

- for those enrolled in Medicare and covered under a Medicare advantage option offered by the Retiree Health Plan, the date such individual is no longer enrolled in Medicare Part A and Part B,

- for those enrolled in Medicare and covered by a Medicare advantage option offered by the

Retiree Health Plan, the date the dependent's Medicare assignment of benefits to the HMO, under which he/she is enrolled, is no longer valid,

- the date the dependent would be initially covered by Medicare Part A and Part B if such individual enrolled when first eligible but fails to enroll,

- the date the Retiree Health Plan is terminated by the Board of Trustees,

- the date the eligibility rules are modified by the Board of Trustees to exclude a class of dependents in which the dependent belongs,

- the date of entrance into full-time military service with the Armed Forces of the United States, or

- the first day of the month following the date the dependent worked two calendar quarters in Non-Covered Sheet Metal Service.

COBRA coverage may be available to dependents or former dependents upon loss of eligibility, as explained in the COBRA section. Please note that a lapse of health coverage lasting 3 consecutive months may cause you to owe an individual shared responsibility payment pursuant to the Affordable Care Act. The individual shared responsibility payment is due when you file your individual tax return.

You may avoid having to pay the individual shared responsibility payment by becoming covered under another health plan that qualifies as minimum essential coverage. Examples of minimum essential coverage include Retiree Health Plan COBRA coverage, Medicare coverage, or a plan available through the Affordable Care Act Marketplace or Exchange in your area.

More information about the individual shared responsibility provision can be found at the following IRS webpages:

- **"Questions and Answers on the Individual Shared Responsibility Provision" http://www.irs.gov/Affordable-Care-Act/Individuals-and-Families/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision**

- **"Individual Shared Responsibility Provision – Calculating the Payment" http://www.irs.gov/Affordable-Care-Act/Individuals-and-Families/ACA-Individual-Shared-Responsibility-Provision-Calculating-the-Payment**

WORK AFTER RETIREMENT

At age 65 (or at age 55 if a retiree is working in pre-approved employment under the "55/25 Rule") a retired participant may work in otherwise suspendable Sheet Metal Industry employment under rules set forth in the plan booklet for the Sheet Metal Workers' Pension Plan of Southern California, Arizona and Nevada ("Pension Plan") for up to 40 hours per month and continue eligibility under the Retiree Health Plan as well as continue to receive Pension Benefits from the Pension Plan. Such work will not be credited to the participant's hour bank for active eligibility under the Plan, and the retired participant will not be eligible for health coverage under actives Plan A or Plan B by virtue of such employment. At April 1 of the year following the

year a retired participant reaches age 70-1/2, the participant's work in the Sheet Metal Industry is unrestricted, and the retiree may establish active Plan A or Plan B coverage by virtue of such employment, unless it is work under the 55/25 Rule. If active eligibility is established, coverage under the Retiree Health Plan will terminate as of the effective date of active eligibility.

QUALIFIED MEDICAL CHILD SUPPORT ORDERS

If a court or state administrative agency has issued an order with respect to health care coverage for any dependent child of the participant, a copy of the order should be promptly mailed to the Administrative Office. The Administrator or its designee will determine if that order is a QMCSO. That determination will be binding on the participant, the other parent, the child, and any other party acting on behalf of the child. The Administrator or its designee will notify the parents and each child if an order is determined to be a QMCSO, and if the participant is covered by the Plan and if such participant is entitled to coverage for dependent children and advise them of the procedures to be followed to provide coverage of the dependent child(ren).

If the participant is covered under the Retiree Health Plan and is entitled to coverage for dependent child(ren) in accordance with the eligibility rules set forth in the Retiree Health Plan, the QMCSO may require the Retiree Health Plan to provide coverage for the participant's dependent child(ren) and to accept any required self-pay contributions for that coverage from a parent who is not a participant in the Retiree Health Plan. The Retiree Health Plan will accept a special enrollment of the dependent child(ren) specified by the QMCSO from either the participant or the custodial parent. Coverage of the dependent child(ren) will become effective as of the date the enrollment is received by the Administrative Office, and will be subject to all terms and provisions of the Retiree Health Plan.

If the participant is not covered under the Retiree Health Plan at the time the QMCSO is received, the Administrator will return the documents to the sender and notify all interested parties that coverage under the Retiree Health Plan is not available to the dependent child(ren) until such time the participant becomes covered under the Retiree Health Plan. Similarly, if the participant is not entitled to coverage of his dependent child(ren) in accordance with the eligibility rules set forth in the Retiree Health Plan, the Administrator will return the documents to the sender and notify all interested parties that coverage under the Retiree Health Plan is not available to the dependent child(ren).

No coverage will be provided for any dependent child under a QMCSO unless any applicable participant self-pay contributions for that dependent child's coverage are paid, and all of the Retiree Health Plan requirements for coverage of that dependent child have been satisfied.

COBRA COVERAGE

Who Is Eligible

The Retiree Health Plan COBRA coverage extension is only available to dependents of retired sheet metal workers (not retired sheet metal workers) who are covered under the Retiree Health Plan as dependents and whose coverage is terminating because one of the following qualifying events occur:

- divorce of the retired participant from the retired participant's spouse, or

- a dependent child ceases to meet the qualifications of an eligible dependent under the Retiree Health Plan.

You are NOT eligible for COBRA coverage if you are working in Non-Covered Sheet Metal Service or if your eligibility is lost because of delinquent owner-operator status. COBRA coverage will automatically terminate as of the date you start work in Non-Covered Sheet Metal Service. Once terminated, COBRA coverage cannot be reinstated.

Notification Requirements

COBRA continuation coverage will be offered to qualified beneficiaries only after the Administrative Office has been notified that a qualifying event has occurred. When the qualifying event is divorce of the participant and spouse or a dependent child's losing eligibility for coverage, the participant or dependent is responsible for giving notice to the Administrative Office as soon as possible but not later than 60 days after the date of the qualifying event or the date coverage under the Retiree Health Plan is lost as a result of the event.

Notice must be received in writing and sent to the following address:

Sheet Metal Workers' Health Plan
Eligibility Department
P.O. Box 10067
Manhattan Beach, CA 90266-8567

If the Administrative Office in Manhattan Beach is not notified in writing within 60 days, the individual(s) whose coverage under the Retiree Health Plan is terminating will not be entitled to continue coverage under COBRA.

After the dependent(s) are notified of their right to elect COBRA coverage, the Administrative Office must be advised, by submission of a completed COBRA enrollment form, of the desire to continue coverage within 60 days after the later of 1) the date Retiree Health Plan coverage would be lost, or 2) the date the dependent(s) were notified of the right to elect COBRA coverage.

If the COBRA enrollment form is not properly completed and submitted to the Administrative Office within the time limit specified above, the individuals whose coverage under the Retiree Health Plan is terminating will not be entitled to continue coverage under COBRA except as provided under "Special COBRA Enrollment Rights" later in this Chapter.

Each dependent has an independent right to elect COBRA coverage.

Type of Coverage

COBRA coverage consists of the same Retiree Health Plan medical and prescription drug benefits provided to similarly situated dependents for whom a qualifying event has not occurred.

COBRA participants may change their coverage selections on the same basis as retired participants as described on page 10 under ANNUAL OPEN ENROLLMENT.

Cost of and Payment for COBRA Coverage

COBRA participants must pay for COBRA coverage on a monthly basis. The cost of coverage is based on the Plan's costs to provide coverage to participants and eligible dependents under the Retiree Health Plan. The current self-payment rates are included in the COBRA enrollment material sent by the Administrative Office. The initial self-payment for COBRA coverage must be submitted directly to the Administrative Office within 45 days from the date the participant submitted a completed COBRA enrollment form to the Administrative Office. The initial payment must cover the number of months from the date coverage would otherwise have terminated through the month in which the initial payment is made.

If your spouse or dependent child(ren) have elected COBRA coverage, and the amount required for COBRA coverage has not been paid while the 45-day grace period for payment is still in effect and a health care provider requests confirmation of coverage, COBRA coverage will be confirmed. However, the notice to the provider will state that the cost of the COBRA coverage has not been paid and that the COBRA coverage will terminate effective as of the due date of any unpaid amount if payment of the amount due is not received by the end of the grace period.

If the initial self-payment in the proper amount is not submitted to the Administrative Office within the 45-day period described above, the election of COBRA continuation coverage shall be automatically revoked and considered void and the participant and/or dependent(s) whose coverage under the Plan is terminating will not be entitled to continue coverage under this COBRA extension.

Subsequent self-payments must be made monthly to continue coverage. Monthly payments should be mailed by the 20th day of the month preceding each coverage month to avoid possible delays in claim payments and eligibility problems. Failure to make a monthly payment within 30 days following the beginning of the coverage month will result in termination of coverage as of the end of the period for which payment has been made. Once terminated, COBRA coverage cannot be reinstated.

The Administrative Office will not send monthly bills or warning notices. It is your responsibility to submit payments when due.

Continuation Period for COBRA Coverage

For each qualified beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date coverage under the Retiree Health Plan would otherwise have ended and will be extended for a maximum of 36 months even if another qualifying event occurs while you are enrolled in COBRA.

Termination of COBRA Coverage

Once COBRA coverage has been elected, it may be cut short (terminated) on the occurrence of any of the following events:

- termination of the Retiree Health Plan,
- failure to pay the required premium in full and on a timely basis,
- you become covered, after your COBRA election date, under another group health plan,
- you become enrolled in Medicare after your COBRA election date,
- you work in Non-Covered Sheet Metal Service.

Newly Acquired Dependents

If a COBRA beneficiary (as that term is defined by law) acquires a new dependent while enrolled in COBRA coverage, the new dependent can be enrolled under the COBRA beneficiary's coverage option upon the proper submission of documentation and payment of the applicable self-payment rate within 31 days from the date dependency status was met.

Loss of Other Group Health Plan Coverage or Other Health Insurance Coverage

If, while a COBRA beneficiary is enrolled in COBRA coverage, the beneficiary's spouse or dependent child loses coverage under another group health plan, the COBRA beneficiary may enroll the spouse or dependent child in COBRA coverage for the balance of the extension period. The spouse or dependent must have been eligible but not enrolled in COBRA because of other coverage under a group health plan or other health insurance.

The COBRA beneficiary must enroll the spouse or dependent within 31 days after the termination of the other coverage. Adding a spouse or dependent child may increase the cost for COBRA coverage.

The loss of other coverage must be due to: (a) exhaustion of COBRA coverage under the other plan, (b) termination as a result of loss of eligibility, (c) termination of the employer's contribution toward the other coverage, or (d) moving out of an HMO service area if HMO coverage terminated for that reason. Loss of eligibility does not include a loss due to failure of the individual to pay premiums on a timely basis or termination for cause.

Other Events

If, while a COBRA beneficiary is enrolled in COBRA continuation coverage under the Retiree Health Plan, his or her eligible dependent who is not enrolled in COBRA coverage under the Retiree Health Plan loses coverage through Medicaid or a State children's health insurance program (CHIP) or becomes eligible for a premium assistance program through Medicaid or CHIP, the COBRA beneficiary may enroll the eligible dependent for COBRA coverage under the Retiree Health Plan for the balance of the period of COBRA continuation coverage. The spouse or dependent must have been eligible for COBRA coverage as of the date of the initial Qualifying Event, but have not enrolled.

The COBRA beneficiary must enroll the spouse or dependent *within 60 days* after the date

Medicaid or CHIP coverage is lost or the date the spouse or dependent is determined to be eligible for premium assistance.

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Administrative Office informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Administrative Office.

If You Have Questions

If you have questions about your COBRA continuation coverage, you should contact the Eligibility Department of the Administrative Office or you may contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa.

Conversion to Individual Coverage

Under certain circumstances, retired participants and eligible family members whose coverage through an HMO/EPO ends, may be allowed to purchase individual conversion coverage through their HMO/EPO without evidence of insurability. Individuals must apply for conversion coverage and pay the premium within 31 days of the loss of their coverage.

To take advantage of this provision, your individual coverage must be through the same HMO/EPO plan. For more information, contact your HMO/EPO.

CHAPTER 2 - MEDICARE AND PLAN BENEFITS

In this Chapter you'll find:

- **General information about Medicare**
- **How to enroll in Medicare**
- **Medicare assignment**
- **Medicare Part D prescription drug information**

GENERAL MEDICARE INFORMATION

Medicare benefits are available to individuals age 65 or older, individuals who have been on Social Security disability benefits continuously for two years, and individuals with end-stage renal disease (ESRD). It is important that you enroll in this extensive program of health insurance (Parts A and B) promptly upon eligibility.

YOUR COVERAGE UNDER THE RETIREE HEALTH PLAN WILL TERMINATE WHEN YOU BECOME ELIGIBLE FOR MEDICARE UNLESS YOU HAVE ENROLLED IN MEDICARE PARTS A AND PART B AND ASSIGN YOUR MEDICARE BENEFITS TO THE HMO PLAN UNDER WHICH YOU ARE COVERED.

HOW TO ENROLL IN MEDICARE

If you are approaching age 65, you are not automatically enrolled in Medicare unless you have filed an application and established eligibility for a monthly Social Security benefit. If you have not applied for Social Security benefits, you must file a Medicare application form during the 3-month period prior to the month in which you become 65 years of age in order for coverage to begin at the start of the month in which you reach age 65. Call or write your nearest Social Security office 90 days prior to your 65th birthday and ask for an application card.

If you will become eligible for Medicare before age 65, please notify the Administrative Office prior to the date of your Medicare eligibility.

MEDICARE ASSIGNMENT

Regarding the assignment or reassignment of your Medicare benefits to an HMO offered by the Retiree Health Plan, please note the following:

- You may only assign your Medicare benefits to one health care plan at a time;

- To terminate your assignment, you must complete and submit a special Medicare release form available from the HMO or the Administrative Office. The completed form should be submitted to the Administrative Office. You will need to submit the Medicare release form if, for example, you are terminating your HMO coverage through the Retiree Health Plan and are replacing it with an individual Medicare supplement plan. If you are changing from one HMO to another within the Retiree Health Plan, you do **not** have to submit the Medicare

release form (refer to the next arrow).

If you are changing from one HMO to another during the Retiree Health Plan's annual open enrollment, your Medicare benefits are automatically reassigned to the HMO you are transferring to upon submission of a completed enrollment form. There is no need to submit a Medicare release form.

MEDICARE PART D PRESCRIPTION DRUG COVERAGE

Once you become eligible for Medicare, the prescription drug coverage provided to you by your HMO automatically becomes a Medicare prescription drug plan. Since Medicare only allows an individual to enroll in one Medicare prescription drug plan, **it is very important that you do NOT enroll in any other Medicare prescription drug plan offered to you.** If you do, your current medical and prescription drug coverage could be in jeopardy.

What Happens if you Lose or Drop Coverage under the Retiree Health Plan

Your current HMO coverage under the Retiree Health Plan will continue as long as the coverage remains in effect, you remain eligible for it, and the required self-pay contributions are paid on time.

If for some reason you drop or lose your HMO coverage under the Retiree Health Plan, you can then enroll in another Medicare prescription drug plan. **If you do not enroll in another Medicare prescription drug coverage after your current coverage ends**, you may pay more to enroll in Medicare prescription drug coverage later.

Late Enrollment Penalty (also referred to as "Higher Premium Charge")

If you have a gap of 63 days or longer without creditable prescription drug coverage (creditable meaning that drug coverage is at least as good as Medicare's standard prescription drug coverage), and you decide to join a Medicare prescription drug plan, your monthly premium for that Medicare drug coverage will increase by at least 1% per month for every month after you became eligible for Medicare and did not have either Medicare drug coverage or coverage under a creditable drug plan. This is referred to as a late enrollment penalty.

- For example, if 19 months pass during which you do not have creditable prescription drug coverage, when you decide to join Medicare's drug coverage your monthly premium will always be at least 19% higher than what most other people pay. In addition, you may have to wait until the next November to enroll.

You are urged to contact the Administrative Office if you have any questions regarding the assignment of your Medicare benefits.

CHAPTER 3 – OTHER IMPORTANT INFORMATION

This Chapter includes:

- **Privacy of health information**
- **Use and disclosure of protected health information**
- **Claims review procedures**
- **Third party liability**
- **Disclaimers**
- **General Plan provisions**
- **Your rights under ERISA**
- **Plan Facts**

PRIVACY OF HEALTH INFORMATION

The Plan complies with rules included in the Health Insurance Portability and Accountability Act of 1996 (HIPAA) regarding how your health information may be used and disclosed and how you can get access to it. The Plan's Privacy Notice can be viewed online at the Administrative Office's website, www.sheetmetalsam.org, and a copy is available at no charge from the Administrative Office.

It may be necessary for you to complete and submit to the Administrative Office a HIPAA authorization form if you want the Administrative Office to release information about you to someone else such as your Union representative, spouse, or adult child. Likewise, if your spouse or child 18 years of age or older wants the Administrative Office to release information about himself or herself to someone else such as you, it may be necessary for them to complete and submit a HIPAA authorization form. The authorization forms can be obtained from the Administrative Office.

HIPAA: USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

A federal law, HIPAA, as amended by the Health Information Technology for Economic and Clinical Health Act (HITECH), requires that the Plan maintain the privacy of your personally identifiable health information (called **Protected Health Information or PHI**).

- The term **"Protected Health Information" (PHI)** includes all information related to your past, present or future health condition(s) that individually identifies you or could reasonably be used to identify you and is transferred to another entity or maintained by the Plan in oral, written, electronic, or any other form.
- **PHI does not include** health information contained in employment records held by an employer who participates in this Plan in its role as an employer, including but not limited to health information on disability, work-related illness/injury, sick leave, Family and Medical Leave (FMLA), death benefits, life insurance, drug testing, etc.

A complete description of your rights under HIPAA can be found in the Plan's Notice of Privacy Practices, which was previously distributed to you upon enrollment in the Plan and is also available from the Administrative Office and on the Plan's website, www.sheetmetalsam.org. Information about HIPAA in this document is not intended to and cannot be construed as the Plan's Notice of Privacy Practices.

The Plan, and the Plan Sponsor (the Board of Trustees of the Plan), will not use or further disclose information that is protected by HIPAA ("protected health information" or "PHI") except as necessary for treatment, payment, health care operations and Plan administration, or as permitted or required by law. **In particular, the Plan will not, without your written authorization, use or disclose protected health information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor**.

Except as permitted by HIPAA, the Plan will only use or disclose your PHI for marketing purposes or sell (exchange) your PHI for remuneration (payment), with your written authorization. The Plan may disclose PHI to the Plan Sponsor for the purpose of reviewing a benefit claim, appeal or for other reasons related to the administration of the Plan.

A. **The Plan's Use and Disclosure of PHI:** The Plan will use protected health information (PHI), without your authorization or consent, to the extent and in accordance with the uses and disclosures permitted by the privacy regulations under the HIPAA. Specifically, the Plan will use and disclose protected health information for purposes related to health care treatment, payment for health care, and health care operations (sometimes referred to as TPO), as defined below.

- **Treatment** is the provision, coordination or management of health care and related services. It also includes but is not limited to consultations and referrals between one or more of your health care providers. The Plan rarely, if ever, uses or discloses PHI for treatment purposes.
- Payment includes activities undertaken by the Plan to obtain premiums or determine or fulfill its responsibility for coverage and provision of Plan benefits with activities that include, but are not limited to, the following:

  a. Determination of eligibility, coverage, cost sharing amounts (e.g. cost of a benefit, Plan maximums, and copayments as determined for an individual's claim), and establishing employee contributions for coverage;

  b. Claims management and related health care data processing, adjudication of health benefit claims (including appeals and other payment disputes), coordination of benefits, subrogation of health benefit claims, billing, collection activities and related health care data processing, and claims auditing; and

  c. Medical necessity reviews, reviews of appropriateness of care or justification of charges, utilization management, including precertification, concurrent review and/or retrospective review.

- **Health Care Operations** includes, but is not limited to:

  a. Business planning and development, such as conducting cost-management and planning-related analyses for the management of the Plan, development or improvement of methods of payment or coverage policies, quality assessment, patient safety activities;

b. Population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, disease management, contacting of health care providers and patients with information about treatment alternatives and related functions;

c. Underwriting (the Plan does not use or disclose PHI that is genetic information as defined in 45 CFR 160.103 for underwriting purposes as set forth in 45 CFR 164.502(a)(5)(1)), enrollment, premium rating, and other activities relating to the renewal or replacement of a contract of health insurance or health benefits, rating provider and Plan performance, including accreditation, certification, licensing, or credentialing activities;

d. Conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs;

e. Business management and general administrative activities of the Plan, including, but not limited to management activities relating to implementation of and compliance with the requirements of HIPAA Administrative Simplification, customer service, resolution of internal grievances, or the provision of data analyses for policyholders, Plan sponsors, or other customers.

f. Compliance with and preparation of documents required by the Employee Retirement Income Security Act of 1974 (ERISA), including Form 5500's, Summary Annual Reports and other documents].

B. **When an Authorization Form is Needed:** Except with respect to legal spouses, the Plan will require that you sign a valid authorization form (available from the Administrative Office) in order for the Plan to use or disclose your PHI **other than** when you request your own PHI, a government agency requires it, or the Plan uses it for treatment, payment, or health care operations, or other instance in which HIPAA explicitly permits the use or disclosure without authorization. The Plan will automatically disclose PHI related to treatment, payment, or health care operations to a legal spouse, unless an individual completes a valid form to revoke a personal representative, which is available from the Administrative Office.

C. **The Plan will disclose PHI to the Plan Sponsor only** upon receipt of a certification from the Plan Sponsor that the Plan documents have been amended to incorporate the following provisions. With respect to PHI, the Plan Sponsor agrees to:

1. Not use or disclose the information other than as permitted or required by the Plan Document or as required by law;

2. Ensure that any agents, including their subcontractors, to whom the Plan Sponsor provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information. This Plan hires professionals and other companies, referred to as Business Associates, to assist in the administration of benefits. The Plan requires these Business Associates to observe HIPAA privacy rules;

3. Not use or disclose the information for employment-related actions and decisions;

4. Not use or disclose the information in connection with any other benefit or employee benefit plan of the Plan Sponsor, (unless authorized by the individual or disclosed in the Plan's Notice of Privacy Practices);

5. Report to the Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware;
6. Make PHI available to the individual in accordance with the access requirements of HIPAA;
7. Make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA;
8. Make available the information required to provide an accounting of PHI disclosures;
9. Make internal practices, books, and records relating to the use and disclosure of PHI received from the group health Plan available to the Secretary of the Dept. of Health and Human Services (HHS) for the purposes of determining the Plan's compliance with HIPAA;
10. If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made. If return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible; and
11. If a breach of your unsecured protected health information (PHI) occurs, the Plan will notify you.

D. **In order to ensure that adequate separation between the Plan and the Plan Sponsor is maintained** in accordance with HIPAA, only the following employees or classes of employees may be given access to use and disclose PHI:
   1. The Plan's Privacy Officer and Security Officer,
   2. Staff of the Administrative Office that administer the benefits of the Plan including COBRA administration,
   3. Business Associates under contract to the Plan including but not limited to the medical claims administrator, preferred provider organization network, utilization management company, Substance abuse treatment program administrator, and outpatient prescription drug program.

E. The persons described in section D above may only have access to and use and disclose PHI for Plan administration functions that the Plan Sponsor performs for the Plan. If these persons do not comply with this obligation, the Plan Sponsor has designed a mechanism for resolution of noncompliance. **Issues of noncompliance** (including disciplinary sanctions as appropriate) will be investigated and managed by the Plan's Privacy Officer (whose contact information is listed on the Quick Reference Chart at the front of this document).

   If you are a minor and have concerns about the Plan releasing PHI to your parents or guardian, please contact the Privacy Officer.

F. The Plan Sponsor will:
   1. Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of electronic PHI that it creates, receives, maintains or transmits on behalf of the group health plan,
   2. Ensure that the adequate separation discussed in D above, specific to electronic PHI, is supported by reasonable and appropriate security measures,

3. Ensure that any agent, including a subcontractor, to whom it provides electronic PHI agrees to implement reasonable and appropriate security measures to protect the electronic PHI, and
4. Report to the Plan any security incident of which it becomes aware concerning electronic PHI.

G. **Hybrid Entity**: For purposes of complying with the HIPAA Privacy rules, this Plan is a "hybrid entity" because it has both group health plan functions (a health care component of the entity) and non-group health plan functions (such as pension benefits). The Plan designates that its health care group health plan functions are covered by the privacy rules. The health care group health plan functions include the self-funded medical plan options with outpatient prescription drug benefits and COBRA administration.

NON-DISCRIMINATION IN HEALTH CARE

The Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sexual orientation, or sex. The Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, sexual orientation, or sex.

The Plan provides free aids and services to people with disabilities to communicate effectively with the Plan, such as qualified sign language interpreters and written information in other formats such as large print, audio, and accessible electronic formats. The Plan also provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages.

If you believe that the Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with the Plan and/or take other available actions.

For more information, contact the Civil Rights Coordinator for the Plan at the Administrative Office, or visit the Plan's website at www.sheetmetalsam.org.

CLAIMS REVIEW PROCEDURES

These claims review procedures apply only to claims or appeals that pertain to eligibility for benefits under the Retiree Health Plan. Different claims and appeals procedures apply to health care benefits, treatments or supplies. For those procedures, please refer to the Evidence of Coverage/Disclosure booklet issued by your HMO or EPO. Remember, claims or appeals pertaining to benefits must be directed to your HMO or EPO. These claims and appeals procedures apply **only** to Retiree Health Plan <u>eligibility</u> issues.

When a Claim is submitted, it is identified as a pre-service, urgent care, post-service, or concurrent care Claim.

A "pre-service" Claim is a Claim for eligibility for a benefit for which the Plan requires approval before medical care is obtained. (An example would be a request for prior approval of an organ

transplant.)

An "urgent care" Claim is a pre-service Claim for eligibility for medical care or treatment that, if normal "pre-service" Claim standards are applied, could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or, in the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. (An example of this type of Claim would be a request for prior approval of a diagnostic test for appendicitis.)

A "concurrent care" Claim is a Claim for eligibility to continue a previously approved ongoing course of treatment. (Examples would be (1) a Claim to reinstate a previously approved five-day inpatient hospital stay after the Plan determined, upon review of the claim, that it was appropriate to reduce the hospital stay to three days; or (2) a Claim to extend to eight days an inpatient hospital stay originally approved for five days.)

A "post-service" Claim is a Claim for eligibility for benefits that is not a "pre-service," "urgent care," or "concurrent care" Claim. (An example would be a Claim for benefits for diagnostic tests already performed.)

Timing of Initial Claims Decisions

A determination on your claim will be made within the following time frames:

An initial determination on **urgent care Claims** will be made by the Plan or its authorized designee within 72 hours from receipt of the Claim. If the Plan or its authorized designee notifies the claimant within 24 hours of receipt of the Claim that additional information is needed to make a determination on the Claim, the claimant will have 48 hours to respond. The deadline for the initial determination will then be suspended for 48 hours or until the information is received.

An initial determination on **pre-service Claims** will be made by the Plan or its authorized designee within 15 calendar days from receipt of the Claim (30 calendar days if additional information is needed and the Plan informs the claimant of the extension within 15 days from receipt of the Claim). If additional information is needed from the claimant, the claimant will have 45 days to respond. The deadline for the initial determination will then be suspended for 45 days or until the information is received. The claimant will be notified of the decision within 15 days after the additional information is received or the end of the 45-day response period whichever is earlier.

An initial determination on **post-service Claims** will be made by the Plan or its authorized designee within 30 calendar days from receipt of the Claim (45 calendar days if additional information is needed and the Plan informs the claimant of the extension within 30 days from receipt of the Claim). If additional information is needed from the claimant, the claimant will have 45 days to respond. The deadline for the initial determination will then be suspended for 45 days or until the information is received. The claimant will be notified of the decision within 15 days after the additional information is received or the end of the 45-day response period whichever is earlier.

A reconsideration of eligibility for a benefit with respect to a **concurrent care Claim** will be made by the Plan or its authorized designee as soon as possible, but in any event early enough to allow the claimant to have an appeal decided before eligibility for the benefit is reduced or terminated. Any request by a claimant to extend eligibility for an approved urgent care treatment will be acted upon by the Plan or its authorized designee within 24 hours of receipt of the Claim, provided the Claim is received at least 24 hours prior to the expiration of the approved treatment. If the request to extend eligibility for a course of treatment involving urgent care is not received at least 24 hours prior to the expiration of the approved treatment, the request will be treated as an urgent care Claim and will be processed in accordance within the time frames applicable to such Claims.

Claims are processed according to the Retiree Health Plan's rules. The initial determination of your Claim, made by the Plan or its authorized designee, will be provided in writing (with the exception of urgent care notifications, which may be provided orally within 72 hours and then confirmed in writing up to three days later).

Denied Claims (Adverse Benefit Determinations)

Whenever your claim is denied in whole or in part, you will be provided notice of the Adverse Benefit Determination. Notice will be either in the form of correspondence or an explanation of benefits (EOB) from the Plan or its authorized designee.

Adverse Benefit Determinations involving Urgent Claims may be provided to the claimant orally and written notification will also be furnished to the claimant not later than 3 days after the oral notification.

Written notices will include the following information:

- information sufficient to identify the claim involved;
- the specific reason(s) for the determination, including a denial code, if any, and its corresponding meaning and a discussion of the decision, as well as any Plan standards used in denying the claim,
- reference to the specific Retiree Health Plan provision(s) on which the determination is based,
- a description of any additional material or information necessary if you want a further review of the claim and an explanation of why the material or information is necessary,
- an explanation of the Retiree Health Plan's first and second level appeal and the external review process, along with any time limits and information regarding how to initiate the next level of review,
- a statement of your right to bring a civil action under ERISA Section 502(a) following an adverse appeal determination (civil actions must be brought within one year of a final and binding decision of the Board of Trustees on your claim or appeal; see page 36),
- if an internal rule, guideline, protocol, or other similar criterion was relied upon in

deciding your claim, either a copy of the rule, guideline, protocol or other similar criterion, or a statement that it was relied upon in deciding your claim and that it is available upon request at no charge, and

- disclosure of the availability of, and contact information for, any applicable ombudsman established under the Public Health Services Act to assist individuals with internal claims and appeals and external review processes.

For pre-service claims, you will receive notice of the determination orally or in writing even when the claim is approved. If the Adverse Benefit Determination concerns an Urgent Claim, the notice will contain a description of the expedited review process applicable to such claims.

If you do not understand English and have questions about a claim denial, contact the Administrative Office (contact information is listed on the Quick Reference Chart).

- **SPANISH (Español): Para obtener asistencia en Español, llame al 800-947-4338.**
- **TAGALOG (Tagalog): Kung kailangan niyo ang tulong sa Tagalog tumawag sa 800-947-4338.**
- **CHINESE (中文): 如果需要中文的帮助，请拨打这个号码 800-947-4338.**
- **NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 800-947-4338.**

Internal Appeal of an Adverse Benefit Determination

If your claim is denied in whole or in part or you disagree with the decision made on a claim, you may ask for a review (appeal the decision). This Plan maintains a two-level appeals process. Appeals must be submitted in writing (with the exception of urgent care appeals, which may be oral) to the Administrative Office. The Administrative Office must receive the request for review within 180 days from the date of your receipt of the answer with which you disagree. Late requests may be rejected as untimely. You may submit any additional evidence or argument to support your position.

A review will then be made by the Eligibility Committee, which is a Committee of the Board of Trustees of the Plan whose members are appointed by the Board. The Eligibility Committee will independently consider all comments, documents, records, and other information submitted by you or your authorized representative relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

You will be advised in writing of the decision of the Eligibility Committee. This will include a written explanation giving detailed reasons for any denial, specific reference to the Plan provisions on which the denial is based, a description of any additional material or information necessary for you to perfect the claim and an explanation of why such material or information is necessary, and a description of the Plan's review procedures and applicable time limits, including a statement of your right to bring a civil action under Section 502(a) of ERISA following completion of the Plan's two-level appeals process. (Civil actions must be brought within one year of a final and binding decision of the Board of Trustees on your claim or appeal; see page 36.)

This written explanation of the Eligibility Committee's decision will be provided to you within 72 hours from the receipt of the appeal for urgent care claim appeals, within 15 days for pre-

service claim appeals, within 30 days for post-service claim appeals, and prior to termination of the benefit for concurrent care claim appeals.

The determination of the Eligibility Committee is appealable to the Appeals Committee. The Appeals Committee is a Committee of the Board of Trustees of the Plan whose members are appointed by the Board of Trustees. The Appeals Committee and the Eligibility Committee are made up of different individuals; there is no overlap. After the written explanation concerning the Eligibility Committee's determination is received, if you believe you are adversely affected by such decision you or a duly authorized representative of your choice may file a request for an appeal to the Appeals Committee.

The request for appeal must be in writing and submitted to the Administrative Office. The request for appeal must be received by the Administrative Office within 180 days from the date of your receipt of the written explanation of the Eligibility Committee's determination. Late requests may be rejected as untimely. You may submit any additional evidence or argument to support your position. You may also be provided, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to your claim for benefits.

The request for appeal must contain an outline of the matter involved along with any issues, comments or explanations of the applicant's position. Additional written documentation may also be submitted. The applicant may also request that the applicant and/or the applicant's authorized representative be present at the Appeals Committee meeting. A notification of the meeting date and time will then be sent to the applicant who asks for an appearance. Additional evidence can be presented at the Appeals Committee meeting.

The Appeals Committee will independently consider the appeal using the written application presented by you, and/or by hearing the appeal of the individual who has requested a personal appearance at the Appeals Committee hearing. You will be advised in writing of the decision of the Appeals Committee. This will include specific reasons and references to pertinent Plan provisions or documents on which the decision is based; a statement of your rights to receive, upon request and free of charge, reasonable access to, and copies, of all documents, records, and other information relevant to your Claim; and a statement of your right to bring a civil action under Section 502(a) of ERISA. (Civil actions must be brought within one year of a final and binding decision of the Board of Trustees on your claim or appeal; see page 36.)

The decision of the Appeals Committee is final and binding upon the applicant.

The decision of the Appeals Committee will be given to you in writing within 15 days from receipt of the appeal for pre-service and urgent care Claim appeals, within 30 days for post-service Claim appeals, and prior to termination of the benefit for concurrent care Claim appeals.

This appeals procedure shall be the sole and exclusive procedure available to an individual who is dissatisfied with an eligibility decision of any kind relating to a covered Claim. The Plan's appeals procedures must be exhausted before the applicant can avail himself of any procedure outside of the rules and regulations of the Plan itself. However, with respect to urgent care Claims only, applicants need not file an appeal with the Appeals Committee before resorting to outside procedures; in such instances the decision of the Eligibility Committee shall be

considered the final decision of the Plan binding upon the applicant.

Elimination of Conflict of Interest

To ensure that the persons involved with adjudicating claims and appeals (such as claim adjudicators and medical experts) act independently and impartially, decisions related to those persons' employment status (such as decisions related to hiring, compensation, promotion, termination, or retention), will not be made on the basis of whether that person is likely to support a denial of benefits.

Review Process

All appeals will be reviewed and decided by the Plan's third-party vendors or by the Appeals Committee of the Board of Trustees of the Plan. The Appeals Committee has full discretionary authority to determine all questions of eligibility for benefits, including the discretionary authority to make all factual determinations and to construe any terms of the Plan. The Appeals Committee will decide all second-level appeals.

For all appeals, claimants may submit written comments, documents, records, and other information relating to the claim for benefits.

For all appeals, a claimant shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for eligibility for benefits. A document, record, or other information is relevant to a claim if it:

- Was relied on in making the benefit determination;

- Was submitted, considered, or generated in the course of making the eligibility determination, regardless of whether it was relied upon in making the eligibility determination; or

- Demonstrates compliance with the Plan's administrative processes and safeguards designed to ensure and to verify that eligibility claim determinations are made in accordance with governing Plan documents and that, where appropriate, Plan provisions have been applied consistently with respect to similarly situated claimants.

Review of all appeals shall take into account all comments, documents, records, and other information submitted by the claimant relating to the claim for eligibility, without regard to whether such information was submitted or considered in the initial eligibility determination.

New or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the claim for eligibility, regardless of whether it was relied upon in making the eligibility determination, will be provided to the claimant free of charge. The Plan will provide the information as soon as possible and sufficiently in advance of the date on which the notice of final internal Adverse Benefit Determination is required to be provided.

Review of all appeals will afford no deference to the initial Adverse Benefit Determination (or to the previous appeal decision, in the case of a second level appeal).

No appeal decision will be made by the individual who made the Adverse Benefit Determination that is the subject of the appeal (or by any individual who decided a previous level of appeal), or by a subordinate of any such individual.

Time Frames for Notice of Decision on Appeal

You will receive notice of the decision made on your appeal according to the following timetable:

- **Pre-service claims:** You will be sent a notice of a decision on review within **15 days** of receipt of the appeal by the Administrative Office (1st-level appeal) and 15 days of receipt of the appeal by the Administrative Office (2nd-level appeal).

- **Urgent care claims:** You or your representative will be notified of the determination as soon as possible but no later than 72 hours after receipt of the appeal.

- **Concurrent care decisions:** You will receive notice of a decision on review **before reduction or termination** of a treatment in progress.

- **Post-service claims:** Ordinarily, decisions on first-level appeals involving post-service claims will be made by the Eligibility Committee within 30 days after receipt of the appeal. Decisions on second-level appeals to the Appeals Committee will ordinarily be decided at the next regularly scheduled meeting of the Appeals Committee of the Board of Trustees following receipt of your request for review. However, if your request for review is received within 15 days of the next regularly scheduled meeting, your request for review may be considered at the second regularly scheduled meeting of the Eligibility Committee following receipt of your request. In special circumstances, a delay until the third regularly scheduled meeting following receipt of your request for review may be necessary. You will be advised in writing in advance if this extension will be necessary. Once a decision on review of your claim has been reached, you will be notified of the decision as soon as possible, but no later than 5 days after the decision has been reached.

The decision on any review of your claim will be given to you in writing. The written notice will contain the following:

- Information sufficient to identify the claim involved;

- Whether, and the extent to which, the original Adverse Benefit Determination is upheld or reversed;

- A discussion of the decision;

- If the Adverse Benefit Determination is upheld, in whole or in part, the notice will state the specific reason or reasons for the adverse determination including a denial code, if any, and its corresponding meaning;

- Reference to the specific Retiree Health Plan provisions on which the benefit determination is based;

- A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for eligibility;

- A description of available external review processes, including how to initiate an external review;

- The availability of, and contact information for, any applicable office of health insurance consumer assistance to assist individuals with the internal claims and appeals and external review processes;

- A statement of the claimant's right to bring an action under section 502(a) of ERISA following exhaustion of administrative remedies; and

- If the original Adverse Benefit Determination is upheld, in whole or in part, the notice will state whether an internal rule, guideline, protocol, or other similar criterion was relied upon in making any adverse determination, and if so, either the specific rule, guideline, protocol, or other similar criterion, or a statement that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the claimant upon request.

The decision of the Appeals Committee is the final internal Adverse Benefit Determination and is binding on the Plan. Following a final internal Adverse Benefit Determination, if the claimant continues to believe that the decision is contrary to the terms of the Plan, he or she has the right to request an external review or bring a civil action challenging the decision under section 502(a) of ERISA, 29 U.S.C. §1132(a). However, no legal or equitable action for benefits under the Plan may be brought unless and until the final internal Adverse Benefit Determination has been completed and a decision rendered. Any suit or claim must be filed within one (1) year of the decision of the Appeals Committee (see page 36).

If the Plan fails to strictly adhere to all of the above requirements, the claimant is deemed to have exhausted the internal claims and appeals process. The claimant can then pursue an external review or sue under section 502(a) of ERISA on the basis that the Plan has failed to provide a reasonable internal claims and appeals process that would yield a decision on the merits of the claim. If a claimant chooses to sue under Section 502(a) of ERISA, the claim or appeal is deemed denied on review without exercise of discretion by an appropriate fiduciary. However, the claimant will not be deemed to have exhausted the internal claims and appeals process if the failure to strictly adhere to all of the requirements consists of de minimis violations that do not cause, and are not likely to cause, prejudice or harm to the claimant.

External Review of Denied Claims

Time Frame and Procedures for Standard External Review

External Review Procedures: Your Obligations. You may request an external review, by an Independent Review Organization ("IRO"), only in the situation where your appeal of a health care claim, whether urgent, concurrent, pre-service, or post-service claim, is denied and the denial is due to a Rescission of coverage (retroactive elimination of coverage), regardless of whether the Rescission has any effect on any particular benefit at that time.

External review is not available for any other types of denials concerning eligibility under the Retiree Health Plan.

The Plan assumes responsibility for fees associated with External Reviews. Generally, you may only request external review after you have exhausted the internal claims and appeals process described above. This means that, in the normal course, you may only seek external review after a final determination has been made on an appeal. For more information about the External Review procedures, contact the Administrative Office.

A request for an external review must be submitted, in writing, by the claimant or his authorized representative, to the Plan within four months after the date of receipt of a notice of an Adverse Benefit Determination or final internal Adverse Benefit Determination. Within five business days following the date of receipt of the external review request, the Plan will complete a preliminary review of the request to determine whether the request is eligible for external review.

Within one business day after completion of the preliminary review, the Plan will issue a notification in writing to the claimant.

If the request is complete and eligible for external review it will be sent to an Independent Review Organization (IRO) for review. If the request is complete but not eligible for external review, the notification will include the reasons for its ineligibility and contact information for any applicable office of health insurance consumer assistance. If the request is not complete, the notification will describe the information or materials needed to make the request complete. In addition, the Plan will allow a claimant to perfect the request for external review within the four-month filing period or within the 48-hour period following the receipt of the notification, whichever is later.

The assigned IRO will timely notify the claimant in writing of the request's eligibility and acceptance for external review. The notice will include a statement that the claimant may submit in writing to the assigned IRO additional information that the IRO must consider when conducting the external review; however, the additional information must be received within 10 business days following the date of receipt of the notice.

The IRO will review all of the information and documents timely received. In reaching a decision, the assigned IRO will review the claim de novo and not be bound by any decisions or conclusions reached during the Plan's internal claims and appeals process. In addition to the documents and information provided, the assigned IRO, to the extent the information or

documents are available and the IRO considers them appropriate, will consider the following in reaching a decision:

- The claimant's applicable records;

- Reports and other documents submitted by the Plan, claimant, or the claimant's authorized representative;

- The terms of the claimant's plan to ensure that the IRO's decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law; and

- The opinion of the IRO's reviewers to the extent the information or documents are available and the reviewers consider appropriate.

The assigned IRO must provide written notice of the final external review decision within 45 days after the IRO receives the request for the external review. The IRO must deliver the notice of final external review decision to the claimant and the Plan.

The assigned IRO's decision notice will contain:

- A general description of the reason for the request for external review, including information sufficient to identify the claim;

- The date the IRO received the assignment to conduct the external review and the date of the IRO decision;

- References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;

- A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;

- A statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to either the Plan or the claimant;

- A statement that judicial review may be available to the claimant; and

- Current contact information, including phone number, for any applicable office of health insurance consumer assistance.

After a final external review decision, an IRO must make records available for examination by the claimant, Plan, or State or Federal oversight agency upon request, except where disclosure would violate State or Federal privacy laws.

Upon receipt of a notice of a final external review decision reversing the Adverse Benefit Determination or final internal Adverse Benefit Determination, the Plan immediately must

provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim.

Time Frame and Procedures for Expedited External Review

A claimant may request an expedited external review with the Plan at the time the claimant receives:

- An Adverse Benefit Determination if the Adverse Benefit Determination involves a medical condition of the claimant for which the timeframe for completion of an expedited internal appeal would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function and the claimant has requested a request for an expedited internal appeal; or
- A final internal Adverse Benefit Determination, if the claimant has a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function, or if the final internal Adverse Benefit Determination concerns an admission, availability of care, continued stay, or health care item or service for which the claimant received Emergency services, but has not been discharged from a facility.

Immediately upon receipt of the request for expedited external review, the Plan must determine whether the request meets the reviewability requirements for standard external review. The Plan must immediately send a notice to the claimant of its eligibility determination.

Upon a determination that a request is eligible for external review following the preliminary review, the Plan will assign an IRO. The Plan must provide all necessary documents to the assigned IRO as expeditiously as possible.

The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the information or documents submitted. In reaching a decision, the assigned IRO must review the claim de novo and is not bound by any decisions or conclusions reached during the Plan's internal claims and appeals process.

The assigned IRO must provide notice of the final external review decision as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within 48 hours after the date of providing that notice, the assigned IRO must provide written confirmation of the decision to the claimant and the Plan.

Deadline for Filing Suit Following Denial of Appeal (or Denial of Claim in no Appeal): Any civil action under Section 502(a) of ERISA, challenging an actual or perceived denial of a claim for eligibility under the Retiree Health Plan, in whole or in part, must be filed within one year of the date of a final and binding decision of the Board of Trustees denying the claim or an appeal relating thereto. If no appeal was filed, even though appeals are required as a condition of filing suit, then suit must be brought within one year of the date of the Plan's denial of the claim.

DISCLAIMERS

- All of the HMO and EPO benefits offered under the Retiree Health Plan are insured by the respective HMOs or EPO. The Board of Trustees has no obligation to provide any benefit other than payment of monthly premiums due in accordance with the service agreements between the Plan and the HMOs and EPOs.

- The only sources of authorized information are this SPD, the providers' benefit booklets, and booklet inserts, if any, the Trust Agreement for the Health Plan, the Service Agreements between the Plan and the HMOs and EPOs, and the written statements of the Plan Administrative Office on behalf of the Plan, and the written statements of duly authorized representatives of the HMOs and EPOs with respect to benefits and coverages under those plans.

- Your rights with respect to eligibility and benefits under the Plan are determined by the agreements with service providers and the Plan's eligibility provisions as set forth in this booklet, and any booklet inserts. In the event of any conflict between the provisions contained in the agreements with service providers and the provisions contained in this booklet, including any inserts, the provisions contained in this booklet and inserts shall prevail.

- Retired participants have no accrued or vested rights to benefits under the Plan. In the event the Plan is terminated by the Board of Trustees, the rights of all participants covered under the Plan with respect to any benefits available subsequent to termination, will be determined by the Board of Trustees, in its sole and absolute discretion in accordance with procedures specified in the Trust Agreement.

- The Board of Trustees expressly reserves the right at any time and from time to time for any reason, in its sole and absolute discretion, in accordance with the procedures specified in the Trust Agreement:

  - to terminate or amend the amount or eligibility conditions with respect to any benefit, to terminate or change any benefit, or to add or modify any self-payment, even though such changes may affect claims which have already accrued,

  - to terminate the Plan and/or any other health coverage offered through the Plan even though such termination affects claims which have already accrued,

  - to alter or postpone the method of payment of any benefit, or

  - to amend or rescind any other provision of the Plan.

- If you or a provider call the Administrative Office to inquire about eligibility or health care options, the Administrative staff can only describe Plan options and verify eligibility, in general, based upon information provided, thus far, and subject to all terms of the Plan. Verification does not guarantee or validate eligibility or your health care options.

- Neither the Plan, its Board of Trustees, or any of their designees are engaged in the practice of medicine, nor do any of them have any control over any diagnosis, treatment, care or lack thereof, or any health care services provided or delivered to you by any health care provider. Neither the Plan, its Board of Trustees, nor any of their designees, will have any liability whatsoever for any loss or injury caused to a Plan participant or beneficiary by any health care provider by reason of negligence, failure to provide care or treatment, or otherwise.

GENERAL PLAN PROVISIONS

Discretionary Authority

In carrying out their respective responsibilities under the Plan, the Board of Trustees, and other Plan fiduciaries and individuals to whom responsibility for the administration of the Plan has been delegated, have discretionary authority to interpret the terms of the Plan and to determine eligibility and entitlement to Plan benefits in accordance with the terms of the Plan. Any interpretation or determination made under that discretionary authority will be given full force and effect. The Board of Trustees retains the sole and absolute discretion to interpret the provisions of the Plan and to make the necessary factual determinations regarding eligibility for benefits or any other issue regarding the Plan.

Worker's Compensation Not Affected

The benefits provided by the Plan are not in lieu of and do not affect any requirement for coverage by worker's compensation insurance laws or similar legislation.

Trust Agreement

The provisions contained in this booklet and booklet inserts, if any, are subject to and controlled by the provisions of the Trust Agreement under which the Plan is established and maintained, and, in the event of any conflict between the provisions contained in this SPD and booklet inserts and the provisions contained in the Trust Agreement, the provisions of the Trust Agreement shall prevail.

Right to Receive and Release Necessary Information

For the purpose of determining eligibility under the Retiree Health Plan, the Administrative Office may, with the consent of the retired participant and consistent with applicable law, release to or obtain from an insurance company, employer, or other organization or person, any information with respect to any person which the Plan's Administrative Office deems to be necessary for such purposes. Any retired participant or dependent claiming benefits under the Plan must furnish to the Plan's Administrative Office all such information as may be necessary to implement this provision.

Right of Recovery

Whenever payments have been made by the Plan, at any time, in excess of the amount of payment that should have been made at that time to satisfy the benefit provisions of the Retiree Health Plan, the Plan shall have the right to recover such payments to the extent of such excess

in addition to any necessarily incurred attorney's fees and costs of suit, through any legal or equitable means from among one or more of the following, as the Trustees shall determine:

- any person to or for or with respect to whom such payments were made, or
- any other plan.

In addition, in the event that you make an intentional misstatement of material fact, omit to state a material fact, or commit an act of fraud or dishonesty to the detriment of the Plan, you or your dependents (or any individual claiming to be a dependent through you) will lose all rights to eligibility that you might otherwise have had under the Plan, retroactive to the date of the offending act. Loss of eligibility for one of these reasons is not an event resulting in a right to COBRA continuation coverage. Therefore, upon such an act you or your dependents (or any individual claiming to be a dependent through you) will also lose any right to COBRA continuation coverage that you or your dependents might otherwise have had under the terms of the Plan.

Delinquent Owner-Participants

If a retired participant or spouse has a five percent (5%) or greater ownership interest in the employer contributing on the participant's behalf, no premiums will be paid, nor will COBRA continuation coverage be available, for that individual or his or her dependents if the employer is delinquent in payment of any contributions or any other amounts due to any employee benefit plan under the Collective Bargaining Agreements.

Headings Do Not Modify Plan Provisions

The headings of chapters, subchapters, sections, paragraphs, and subparagraphs are included for the sole purpose of generally identifying the subject matter of the substantive text so that a table of contents can be constructed for the convenience of the reader. The headings are not part of the substantive text of any provision, and they should not be construed to modify the text of any substantive provision in any way.

Pronouns

All pronouns and any variations thereof refer to and include the masculine, feminine, neuter, singular, or plural, as the context may require.

SPECIAL PROVISIONS REGARDING WOMEN'S HEALTH CARE

Federal law guarantees certain rights to women.

Under the Newborns' and Mothers' Health Protection Act of 1996, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (for example, your Physician), after consultation with the mother, discharges the mother or newborn

earlier.

Also, under Federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under Federal law, require that a Physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours).

Under the Women's Health and Cancer Rights Act of 1998, all plans that cover mastectomies are also required to cover related reconstructive surgery. Available reconstructive surgery must include both reconstruction of the breast on which surgery was performed and surgery and reconstruction of the other breast to produce a symmetrical appearance. Coverage must also be available for breast prostheses and for the physical complications of mastectomy, including lymphedema. These services are elective and are chosen by the patient in consultation with the attending Physician. They are subject to the usual deductible, co-insurance, and co-payment provisions.

YOUR RIGHTS UNDER ERISA

As a retired participant in the Sheet Metal Workers' Health Plan of Southern California, Arizona and Nevada, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants are entitled to the following rights:

Receive Information about Your Plan and Benefits

You have the right to:

- Examine, without charge, at the Administrative Office and at other specified locations, such as worksites and union halls, all documents governing the operation of the Plan. These documents include insurance contracts and Collective Bargaining Agreements and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration (formerly the Pension and Welfare Benefits Administration).

- Obtain, upon written request to the Administrative Office, copies of documents governing the operation of the Plan. These include insurance contracts, Collective Bargaining Agreements, copies of the latest annual report (Form 5500 Series), current Plan Document with amendments and updated Summary Plan Description. The Plan Administrator may make a reasonable charge for the copies.

- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

- Continue health care coverage for yourself, spouse, or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review Chapter 1 of this SPD booklet, or HMO booklets, for the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of employee benefit plans. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive it within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a State or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your plan, you should contact the Administrative Office. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration (EBSA) (formerly the Pension and Welfare Benefits Administration), U.S. Department of Labor, listed in your telephone directory. Alternatively, you may obtain assistance by calling EBSA toll-free at (866) 444-EBSA (3272) or writing to the following address:

Division of Technical Assistance and Inquiries
Employee Benefits Security Administration
U.S. Department of Labor
200 Constitution Avenue N.W.
Washington, D.C. 20210

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of EBSA. For single copies of publications, contact the EBSA brochure request line at (800) 998-7542 or contact the EBSA field office nearest you.

You may also find answers to your Plan questions and a list of EBSA field offices at the website of EBSA at http://www.dol.gov/ebsa.

PLAN FACTS

- **NAME OF PLAN:** The Plan is known as the Sheet Metal Workers' Health Plan of Southern California, Arizona and Nevada. The Plan described in this booklet covers retired participants and their dependents under the Retiree Health Plan.

- **PLAN SPONSOR AND ADMINISTRATOR:** The Board of Trustees is both the Plan Sponsor and Plan Administrator. This means that the Board of Trustees is responsible for seeing that information regarding the Plan is reported to governmental agencies and disclosed to Plan participants and beneficiaries in accordance with the requirements of the Employee Retirement Income Security Act of 1974, as amended.

  The Plan is administered and maintained by the Board of Trustees. The routine functions of the Plan are performed by:

  Sheet Metal Benefit Plans Administrative Corporation
  111 North Sepulveda Blvd., Suite 100
  Manhattan Beach, CA 90266

- **IDENTIFICATION NUMBER:** The number assigned to the Plan by the Internal Revenue Service is 95-6052259. The number assigned to the Plan is 501.

- **AGENT FOR SERVICE OF LEGAL PROCESS:** The name and address of the agent designated for the service of legal process is:

  Vernon Shaffer, Executive Director
  Sheet Metal Benefit Plans Administrative Corporation
  111 North Sepulveda Blvd., Suite 100
  Manhattan Beach, CA 90266

  Legal process may also be served on a Plan Trustee.

- **COLLECTIVE BARGAINING AGREEMENTS AND PARTICIPATION AGREEMENTS:** Contributions to the Plan are made on behalf of each employee in accordance with collective bargaining agreements between the Sheet Metal Workers' International Association, local unions and employers in the industry and/or in accordance with participation agreements between such employer and the Plan.

- **SOURCE OF CONTRIBUTIONS:** The benefits described in this booklet are provided through employer contributions and participant self-pay contributions. The amount of employer contributions is determined by the provisions of the collective bargaining agreements or participation agreements with employers or employer representatives. The amount of self-pay contributions is determined in the sole and absolute discretion of the Board of Trustees.

- **TYPE OF PLAN:** The Retiree Health Plan is maintained for the purpose of providing Hospital, Medical, and Prescription Drug benefits in the event of sickness or injury.

- **HEALTH PLAN:** All assets are held in trust by the Board of Trustees of the Sheet Metal Workers' Health Plan of Southern California, Arizona and Nevada and invested in various bank savings accounts and short-term bank investments, government and corporate bonds and certain other investments approved by the Trustees.

- **IDENTITY OF PROVIDER OF SERVICES OR BENEFITS:** HMO and EPO medical programs are provided by Kaiser, Health Net, Health Plan of Nevada, Hometown Health, and United HealthCare. Premiums are paid to the HMOs/EPO on behalf of retired participants and surviving dependents who have elected coverage under the Retiree Health Plan, in turn, those organizations fully insure the benefits provided by them.

  Kaiser, Health Net, United HealthCare/PacifiCare, Health Plan of Nevada, and Hometown Health pay claims and handle claim appeals related to their programs of benefits. These organizations will supply you, upon written request, written materials concerning the nature of services provided, conditions pertaining to eligibility to receive such services (other than general conditions pertaining to eligibility for participation in the Retiree Health Plan) and circumstances under which such services may be denied, the procedures to be followed in obtaining such services, and the procedures available for the review of claims for services which are denied in whole or in part. Requests for such materials may be addressed to the Plan Administrator at the address given in "Plan Sponsor and Administrator" above.

  The names and addresses of the insurance companies and service organizations are:

Health Net
21600 Oxnard Street
Woodland Hills, CA 91367

Health Plan of Nevada (HPN)
3320 West Sahara Avenue
Suite 300
Las Vegas, NV 89114

Hometown Health (HHP)
400 South Wells Avenue
Reno, NV 89502

Kaiser
493 East Walnut
Walnut Center
Pasadena, CA 91188

United HealthCare - Arizona
410 North 44th Street
Phoenix, AZ 85072

United HealthCare - California
5856 Corporate Avenue
Cypress, CA 90630

United HealthCare - Nevada
700 East Warm Springs Road
Las Vegas, NV 89119

- **PLAN YEAR:** The records of the Plan are kept separately for each Plan Year. The Plan year begins January 1 and ends on December 31.

- **THE PLANS REQUIREMENTS WITH RESPECT TO ELIGIBILITY FOR PARTICIPATION AND BENEFITS:** The eligibility requirements are specified in Chapter 1 of this booklet.

- **CIRCUMSTANCES RESULTING IN DISQUALIFICATION, INELIGIBILITY OR DENIAL OR LOSS OF BENEFITS:** Loss of eligibility is described in Chapter 1 of this booklet.

- **CLAIMS FILING AND CLAIMS APPEAL PROCEDURE:** Claims filing and claims appeal procedures are described in the Evidence of Coverage/Disclosure booklets issued by the HMOs and EPOs. Claims and appeals involving issues of eligibility for benefits under the Plan are described in Chapter 3 of this booklet.

This booklet contains a summary in English of your plan rights and benefits under the Sheet Metal Workers' Health Plan of Southern California, Arizona and Nevada. If you have difficulty understanding any part of this booklet, contact the Administrative Office at 111 North Sepulveda Blvd., Suite 100, Manhattan Beach, California 90266. The office hours are from 7 a.m. to 5 p.m., Monday through Friday. You may also call the Administrative Office at (800) 947-4338 for assistance.

GLOSSARY OF TERMS USED IN THIS BOOKLET

Listed below are definitions of some of the terms used in this booklet.

- "**Active Plan**" means the health care options and eligibility rules that have been designated as Plan A or Plan B by the Plan, and which are exclusively provided to eligible active sheet metal workers.

- "**Board of Trustees**" means the Board of Trustees of the Sheet Metal Workers' Health Plan of Southern California, Arizona and Nevada.

- "**Contributing Employer**" means an employer required by a collective bargaining agreement with a participating local union or applicable law to make contributions to the Plan. "Contributing Employer" also means an employer that has agreed to contribute to the Plan on the same basis as any Contributing Employer and that has been approved by the Board of Trustees to participate in the Plan.

- "**EPO**" means Exclusive Provider Organization.

- "**HMO**" means Health Maintenance Organization.

- "**Non-Covered Sheet Metal Service**" means sheet metal work in the geographical jurisdiction of the Sheet Metal Workers' Pension Plan of Southern California, Arizona and Nevada or a related plan (one linked by reciprocal agreements – for more information contact the Administrative Office) for an employer which does not have, or, self-employment which is not covered by, a collective bargaining agreement with a Sheet Metal Workers' union which requires contributions to the Pension Plan or a related plan. It includes all work or services of the kind performed by any Contributing Employer to the Pension Plan that relates in any way to any work of the kind performed by participating employees covered by the Pension Plan. It includes such jobs as management, ownership (including by your spouse), sales, estimating, or consulting positions for Sheet Metal employers or in the Sheet Metal Industry, as well as work of the type done by bargaining unit members and related work.

- "**Pension Benefit(s)**" means a monthly pension benefit from the Sheet Metal Workers' Pension Plan of Southern California, Arizona and Nevada.

- "**Pension Plan**" means the Sheet Metal Workers' Pension Plan of Southern California, Arizona and Nevada.

- "**Plan**" means the Sheet Metal Workers' Health Plan of Southern California, Arizona and Nevada.

- "**Qualified Medical Child Support Order**" (QMCSO) is, according to federal law, a child support order of a court or state administrative agency that usually results from a divorce, that has been received by the Plan, and that meets all of the following requirements:

  - Designates one parent to pay for a child's health plan coverage,
  - Indicates the name and last known address of the parent required to pay for the coverage

and the name and mailing address of each child covered by the QMCSO,
- Contains a reasonable description of the type of coverage to be provided under the designated parent's health care plan or the manner in which such type of coverage is to be determined,
- States the period for which the QMCSO applies, and
- Identifies each health care plan to which the QMCSO applies.

An order is not a QMCSO if it requires the Plan to provide any type or form of benefit or any option that the Plan does not otherwise provide, or if it requires an employee who is not covered by the Plan to provide coverage for a Dependent child, except as required by a State's Medicaid-related child support laws. For a State administrative agency order to be a QMCSO, State statutory law must provide that such an order will have the force and effect of law, and the order must be issued through an administrative process established by State law. An order is not a QMCSO unless it is approved and recognized by the Plan as a QMCSO.

- "**Retired Participant**" (**or "retired participant"**) means a retired sheet metal worker or other individual who meets the eligibility requirements for coverage under the Retiree Health Plan as a retiree.

- "**Retiree Health Plan**" means the health care options and eligibility rules that have been designated as the Retiree Health Plan by the Plan, and which are exclusively provided to eligible retired sheet metal workers.

- "**Sheet Metal Industry**" means all work or services of the kind performed by any Contributing Employer to the Sheet Metal Workers' Pension Plan of Southern California, Arizona, and Nevada, which relates in any way to any work performed by employees covered by the Pension Plan. For example, in addition to manufacturing, fabrication, service, design and installation of products or goods by Contributing Employers, the Sheet Metal Industry includes, but is not limited to, the following functions:
  - an ownership interest in, or any work or consulting for, any establishment which manufacturers, fabricates, services, designs, installs, repairs or sells any items of the type so handled by any Contributing Employer; whether or not the establishment is incorporated and whether or not it contributes to the Pension Plan. If your spouse has any such connection with the Sheet Metal Industry, you are deemed to also have compensation or profit from the Industry. If your spouse has an ownership interest in a sheet metal employer, you are deemed to also have an ownership interest,
  - acting in a sales, consulting, estimating or design capacity relating to any items of the types manufactured, fabricated, serviced, designed, installed, repaired, sold, etc. by any Contributing Employer, or
  - any other work relating in any way to the manufacture, fabrication, service, design, installation, repair or sale of any item of the type handled by any Contributing Employer.

- "**You**" (**or "you"**) means a retired sheet metal worker, dependent, or other individual who meets the eligibility requirements for coverage under the Retiree Health Plan.

MEMBERS OF THE BOARD OF TRUSTEES

The Board of Trustees is responsible for operating the Plan. The Board of Trustees consists of employer and union representatives, selected by the employers and unions in accordance with the Trust Agreement that governs the Plan. If you wish to contact the Board of Trustees, you may use the address of Sheet Metal Benefit Plans Administrative Corporation, 111 North Sepulveda Blvd., Suite 100, Manhattan Beach, California 90266.

The Trustees of the Plan (as of the printing of this booklet) are listed on the next two pages.

LABOR TRUSTEES

Scot Banks
SMART Sheet Metal Workers' Local Union 26
1819 Hymer Avenue
Sparks, Nevada 89431
(775) 352-9226

Donald P. Bennett
SMART Sheet Metal Workers' Local Union 105
2120 Auto Centre Drive, Suite 105
Glendora, California 91740
(909) 305-2800

Chris Gonzalez
SMART Sheet Metal Workers' Local Union 105
620 Enterprise Way, Suite A
Bakersfield, California 93307
(661) 832-1257

Byron K. Harvey
SMART Sheet Metal Workers' Local Union 88
2560 Marco Street
Las Vegas, Nevada 89115-4518
(702) 452-4799

Albert Hernandez
SMART Sheet Metal Workers' Local Union 105
2120 Auto Centre Drive, Suite 105
Glendora, California 91740
(909) 305-2800

Stephen Hinson
SMART Sheet Metal Workers' Local Union 105
2120 Auto Centre Drive, Suite 105
Glendora, California 91740
(909) 305-2800

Timothy Hinson
SMART Sheet Metal Workers' Local Union 105
2120 Auto Centre Drive, Suite 105
Glendora, California 91740
(909) 305-2800

Jeff Holly
SMART Sheet Metal Workers' Local Union 359
2604 E. Adams Street
Phoenix, Arizona 85719
(602) 273-1388

Samuel Hurtado
SMART Sheet Metal Workers' Local Union 105
2120 Auto Centre Drive, Suite 105
Glendora, California 91740
(909) 305-2800

Luther Medina (Labor Co-Chair)
SMART Sheet Metal Workers' Local Union 105
2120 Auto Centre Drive, Suite 105
Glendora, California 91740
(909) 305-2800

David Shaver
SMART Sheet Metal Workers' Local Union 105
2120 Auto Centre Drive, Suite 105
Glendora, California 91740
(909) 305-2800

William (Bill) Shaver
SMART Sheet Metal Workers' Local Union 105
2120 Auto Centre Drive, Suite 105
Glendora, California 91740
(909) 305-2800

Steven C. Sweeting
SMART Sheet Metal Workers' Local Union 104, District 3
1794 Goodyear Avenue
Ventura, California 93003
(805) 658-0053

MANAGEMENT TRUSTEES

Jerry Anderson
Anderson Systems
5958 Corta Street
Goleta, California 93117
(805) 683-6133

William (Bill) R. Assenmacher
T. A. Caid Industries, Inc.
2275 East Ganley Road
Tucson, Arizona 85726
(520) 294-3126

Russ Beaulac
R & R Sheet Metal
12820 E. Lakeland Road
Santa Fe Springs, California 90670
(562) 944-9660

Denny Cagampan III
Wittler-Young Co.
2400 Forney Street
Los Angeles, California 90031
(213) 225-5678

Pete Fortin
ACCO Engineered Systems
6265 San Fernando Road
Glendale, California 91201
(818) 244-6571

Karen Fox
Precision Air Balance Co., Inc.
1240 H – North Jefferson Street
Anaheim, California 92807
(714) 630-3796

Joseph (Joe) Gallagher
Circulating Air, Inc.
7337 Varna Avenue
North Hollywood, California 91605-4009
(818) 764-0530

Randy Journey
Journey Air Conditioning
103 Michigan Street
Bakersfield, California 93307
(661) 322-1633

Fred Klein
Graycon, Inc.
232 8th Avenue
City of Industry, California 91746-3200
(626) 961 -9640

Kurt Marsteller (Management Co-Chair)
Serfass & Company
33562 Yucaipa Blvd., Suite 4-240
Yucaipa, California 92399
(951) 784-1221

Scott McClure
McClure Stainless, LLC
3911 W. Oquendo Road, Suite B
Las Vegas, Nevada 89118
(702) 735-7781

Howell (Tani) Poe, Jr.
Western Allied, Inc.
12046 E. Florence Avenue
Santa Fe Springs, California 90670
(562) 944-6341

Richard Rivera
Key Air Conditioning Contractors
10905 Laurel Avenue
Santa Fe Springs, California 90670
(562) 941-2233

Mike Scolari
RHP Mechanical Systems
1008 East 4th Street
Reno, Nevada 89512
(775) 322-9434